TRIPLE-S VIDA

CANCER AND DREAD DISEASES CHANGE FORM

Insured name: _____ Social Security Number: _____

I request and authorized to process the following changes or services in my cancer policy number: _____

I.	ADDRESS AND TELEPHONE (indicate your new address and telephone number)			
POSTAL ADDRESS *Num. Street PO BOX HC, RR*	CITY	COUNTRY	ZIP CODE	
STREET ADDRESS Area, *Num. Street*	CITY	COUNTRY	ZIP CODE	
PHONE: RESIDENTIAL ( )	WORK ( )	E-MAIL		

II.	COVERAGE REQUESTED				
	Change of Basic Plan From: _____ $_____ TO: _____ $_____ **Current Plan Current Premium Requested Plan Payable Premium**				
PLAN CODE		Individual	Single Father/Mother	Marriage/ Couple	Family
[Z8KU/Z8KV]	BENEFIT INCREASE BY UNITS SABU-0715-352 ❒ INCREASE BENEFIT ❒REDUCE BENEFIT ❒INCLUDING THE RIDER ❒ REMOVING THE RIDER				
[Z8KT]	ORGAN TRANSPLANTS (ETO-1009-282) ❒INCLUDING THE RIDER ❒ REMOVING THE RIDER				
[Z8KA]	ACCIDENTAL DEATH, DISMEMBERMENT, HOSPITALIZATION, CONVALESCENCE (EMAHC-0213-300) Suma Asegurada: $_____ Indemnización Mensual $_____ ❒ INCREASE BENEFIT ❒REDUCE BENEFIT ❒INCLUDING THE RIDER ❒ REMOVING THE RIDER				
[Z8KH]	HOSPITALIZATION AND CONVALESCENCE DUE TO ILLNESS (EHEC-0609-280) [❒ ($25 daily) $750 monthly ❒ ($50 daily) $1,500 monthly ❒ ($75 daily) $2,250 monthly ❒ ($100 daily) $3,000 monthly] ❒ INCREASE BENEFIT ❒REDUCE BENEFIT ❒INCLUDING THE RIDER ❒ REMOVING THE RIDER				
[Z8KJ]	INTENSIVE CARE UNIT (ERCI-0609-281) ❒ $250 daily, $15,000 máx. ❒ $350 daily, $21,000 máx. ❒ $500 daily, $30,000 máx. ❒ $650 daily, $39,000 máx. ❒ INCREASE BENEFIT ❒REDUCE BENEFIT ❒INCLUDING THE RIDER ❒ REMOVING THE RIDER				
[Z8KD]	INCOME FOR TOTAL DISABILITY (Primary Insured only) Ingreso Mensual $_____ OPCION I – Monthly benefits upt o 12 months (EIIT-0609-279) ❒ $250 ❒ $500 ❒ $600 ❒ $700 ❒ $800 ❒ $900 ❒ $1,000 ❒ INCREASE BENEFIT ❒REDUCE BENEFIT ❒INCLUDING THE RIDER ❒ REMOVING THE RIDER				
[Z8KG]	BURNS, FRACTURES, TORNS TENDONS AND LIGAMENTS, LACERATION, MUTILATION, DISPLACEMENT (EQFTLMD-0213-301) ❒INCLUDING THE RIDER ❒ REMOVING THE RIDER				
[Z8KC]	FIRST CANCER DIAGNOSIS (EPDC-0609-276) ($1,000 - $50,000) $ _____ ❒ INCREASE BENEFIT ❒REDUCE BENEFIT ❒INCLUDING THE RIDER ❒ REMOVING THE RIDER				
[Z8KM]	FIRST HEART ATTACK DIAGNOSIS (EPAC-0609-277) ($1,000 - $30,000) $ _____ ❒ INCREASE BENEFIT ❒REDUCE BENEFIT ❒INCLUDING THE RIDER ❒ REMOVING THE RIDER				
[Z8KR]	ONE-TIME PAYMENT FOR RADIOTHERAPY TREATMENT, CHEMOTHERAPY, EXPERIMENTAL THERAPY (SPUR-0816-363) ($1,000 - $20,000) $ _____ ❒ INCREASE BENEFIT ❒REDUCE BENEFIT ❒INCLUDING THE RIDER ❒ REMOVING THE RIDER				
[Z8K1]	HOSPITALIZATION FOR 24 HOURS DUE TO AN ACCIDENT ($1,000 - $2,000) $ _____ ❒ INCREASE BENEFIT ❒REDUCE BENEFIT ❒INCLUDING THE RIDER ❒ REMOVING THE RIDER				
	TOTAL MONTHLY PREMIUM				

III. BENEFICIARIES -This designation will revoke all and every prior designations		
Beneficiaries' complete name	RELATIONSHIP	SOCIAL SEC NUM. / DTOP Id./ LICENSE /PASSAPORT:

IV. ELIGIBLE DEPENDANT or ADDITIONAL INSURED (please answer question in the Insurability Evidence section)			
Complete name	RELATIONSHIP	BIRTH DATE	INCLUDING / REMOVE

V. PAYMENT METHOD			
❒ ANNUAL	❒ SEMI-ANNUAL	❒PAYROLL DEDUCTION (CompletE Authorization)	❒ MONTHLY DEBIT BANK (attached voided check and authorization)

VI.	INSURABILITY EVIDENCE		

CURRENT OCCUPATION: _____

Please, answer the following questions for Cancer, Hospitalization Due to Illness, Disability, Intensive Care or Organ Transplant coverage:

1.	Have you ever been diagnosed with or treated for or are you aware of suffering from any of the following: diabetes, liver, pancreas, kidneys, nephritis, emphysema, tuberculosis, pleurisy, asthma, cystic fibrosis, cancer, bone marrow, epilepsy, arthritis, gout, back pain or any condition related to the musculoskeletal, nervous, circulatory, digestive or respiratory, genitourinary, endocrine or immune system or do you make excessive use of alcohol or habit-causing drugs?	❒ Yes	❒ No
2.	Have you been hospitalized for any reason or have you undergone any surgery in the last five years?	❒ Yes	❒ No
3.	Have you been diagnosed with or have you received treatment for AIDS or ARC? (AIDS-Related Conditions)	❒ Yes	❒ No
4.	Have you ever applied for or are you currently receiving benefits from Social Security, the Puerto Rico State Insurance Fund Corporationor any other public or private insurance that provides disability benefits?	❒ Yes	❒ No
5.	Have you ever been examined for, received treatment or been informed that you suffer from: heart attack, coronary failure, high blood pressure, chest pain, angina, coronary disease, heart/carotid murmur, convulsions, fainting, momentary ischemic attacks?	❒ Yes	❒ No
6.	Have you ever participated or plan to participate in any kind of motor racing, diving, parachuting, hang gliding, ballooning or mountain climbing?	❒ Yes	❒ No
7	Has it been recommended that you undergo a physical checkup, lab tests, biopsies or any other type of test to reveal a possible malignant tumor, leukemia or anything that could be a manifestation of cancer or a dreaded disease?	❒ Yes	❒ No

IF YOU REPLIED "YES" TO ANY QUESTION, MAKE A CIRCLE AROUND THE CONDITION AND PROVIDE DETAILS:

DIAGNOSIS DATE	PERSON'S NAME	CONDITION AND DETAIL	PHYSICIAN WHO TREATED YOU/ADDRESS

I certify hat I have received a copy of the "IMPORTANT NOTICE FOR PEOPLE WITH MEDICARE" as required by Federal Act P.L.103-432. In addition, I certify that I have read the completed application or that it was read to me, and I understand that any false statements or incorrect representations made thereon that are fraudulent or material for acceptance of the risk could result in loss of coverage under the policy. **I further understand that no insurance will take effect until the first premium has been paid**. List active cancer policies with Triple-S Vida, Inc. in the name of the primary insured (if applicable): _____

DECLARATION OF AUTHORIZATION: I authorize any authorized physician, medical practitioner, clinic, hospital or any other medical institution related with the field of medicine, insurance company, MBI, Inc. (MIB) or Pharmacy Benefits Administrator and any other person, organization or institution that has a medical history about me or about any person included in this insurance application to disclose it to Triple-S Vida, Inc. A photocopy of this authorization will be as valid as the original.

I understand that the information obtained through this authorization will be used by Triple-S Vida, Inc. to determine eligibility for benefits, get reinsurance and manage and pay claims. I also understand that under some circumstances the information that was authorized for disclosure to Triple-S Vida, Inc. may in turn be disclosed to individuals or entities that are not subject to medical information privacy laws, in which case said medical information may not be protected by federal medical information privacy laws.

I acknowledge that I have the right to revoke this authorization, in writing, at any time. It is agreed and understood that revoking this authorization will not affect any action that Triple-S Vida, Inc. or its legal representatives or its reinsurers have taken using this authorization prior to receiving its revocation. This authorization is executed as a condition to obtain insurance coverage. By revoking this authorization Triple-S Vida, Inc. will not be able to determine eligibility for benefits, obtain reinsurance or manage and pay claims This authorization will continue to be valid for 30 months or until the application is refused, whichever occurs first, beginning on the date it was signed. Triple-S Vida, Inc. reserves the right to change its Notice of Privacy Practices.

NOTICE "Any person who knowingly and with intent to commit fraud submits false information in an application for insurance or who submits, assists or files a fraudulent claim for the payment of a loss or other benefit, or files more than one claim for the same damage or loss, shall incur in a felony and if convicted, each violation will carry a fine of no less than five thousand (5,000) dollars and no more than ten thousand (10,000) dollars or imprisonment for a fixed term of three (3) years, or both penalties. If there are aggravating circumstances, the established fixed penalty may be increased up to a maximum of five (5) years; if there are extenuating circumstances, it may be reduced to a minimum of two (2) years." Act No. 230 of August 9, 2008.

INSURED SIGNATURE: _____ Date:_____

APPLICANT SIGNATURE, if different from the Primary Insured: _____ Date: _____

I CERTIFY that I personally asked the signatory all the questions included in this application and that I have faithfully written down the information that he/she provided.

Name of Authorized Representative: _____ Agency Name: _____

Authorized Representative's Signature: _____Number: _____Date: _____

Verified by Sales and Marketing:	Risk Assessor: ❒ Approved ❒ App. w/Exc. ❒ Denied	Date:
Observations		

IF PAYMENT WILL BE MADE THROUGH A MONTHLY DEBIT TO YOUR BANK ACCOUNT, INCLUDE A CANCELED CHECK AND SIGN THE AUTHORIZATION FOR MY BANK

As a convenience to me, I hereby request and authorize you to initiate electronic debits to my account and paid to Triple-S Vida, Inc., provided there are sufficient funds available in said account to pay them. I accept that my rights regarding said debit will be the same as if it were a check issued in their favor and signed personally by me. I hereby accept that if any debit is not paid to you for any reason, with or without cause, or if said non-payment is made in an intentional, unnoticed or in some other manner, you will not have any liability, even if said payment is not made on the expiration of the insurance, subject to the Grace Period. This authorization will remain in full force and effect until revoked by me, via written notification 30 days in advance and until you actually receive such notice, I agree that you will be fully protected in honoring any debit to my account.

Bank _____ _____

Name Branch Account Number

Address: _____ Zip Code _____

This authorization is limited to the total cost of the premium. $_____ Account: ❒ Checking ❒ Savings

Signature _____ Date: _____

Proposed Insured

Signature _____ Date: _____

(As it appears on the bank's records)

AUTHORIZATION FOR RECURRING CHARGE TO MY CREDIT CARD

I hereby request and authorize **Triple-S Vida, Inc**. to automatically charge one of the following credit cards.

CREDIT CARD INFORMATION: ❒ VISA ❒ Master Card ❒ American Express

_____ _____ _____

Full Name (as it appears on the credit card) Credit Card No. Expiration Date

_____ _____

Address (as it appears on the card statement) City State Zip Code

This authorization is limited to the ❒ Monthly ❒ Quarterly ❒ Biannual ❒ Annual premium of $ _____ owed in the policy number _____ and is subject to the following: (1) This authorization does not modify any of the policy's terms. (2) **This authorization will remain in effect until it has been cancelled by me through written notification to Triple-S Vida, Inc., at least 30 days before the date when the next premium is due.**

_____ _____ _____

Cardholder's Signature (as it appears on the credit card) Date Address

CONSENT

I am interested in receiving courtesy reminders, information about future services and events offered or sponsored by Triple-S Vida, Inc. I consent to receiving calls from Authorized Representatives as well as prerecorded, automatically dialed phone calls; voice messages and texts; emails by or on behalf of Triple-S Vida, Inc., on the telephone number(s) and email address I supplied. I understand that this consent is not a condition for obtaining the policy for which I am applying.

Email address:_____ Mobile phone:_____ Home phone:_____

Signature:_____

CONSENT FOR ELECTRONIC DELIVERY OF DOCUMENTS

I AUTHORIZE Triple-S Vida Inc. to deliver by electronic transmission to my last email address, any document that they, by provision of law, are required to deliver, notify, give notice or equivalent terms. I **ACKNOWLEDGE** that I must submit a request in writing to the Triple-S Vida Main Office to revoke this consent and request that they deliver the policy or any other document printed on paper, even after receiving it electronically, at no additional cost. I **CONFIRM** that I have access to a computer with Internet service; an active email account to receive electronic information and in which I can read, download and store documents in Adobe Acrobat PDF format. I understand that I must notify Triple-S Vida of: a) any change of email address; b) that I must update those filters in my account that may prevent me from receiving electronic notifications from Triple S Vida, Inc. I **CONSENT,** in the case of there being more than one insured, that the policy Owner, or in his/her absence the Primary Insured, be the one who receives the information sent electronically. I **AGREE** that a change in the manner of delivery or notification of documents will not take effect until it is registered in our Main Office. It is agreed and understood that the revocation of this authorization will not affect any action that Triple-S Vida, Inc. has taken using this authorization prior to receiving the revocation. I am aware that the company reserves the right to cancel the delivery of the policy or the notification of electronic documents if the emails are returned to Triple-S Vida, Inc.'s server. In this case they will proceed with the delivery or notification on paper. Triple S Vida, Inc. is not required by law to deliver documents or notifications electronically and may discontinue electronic deliveries or notifications partially or completely at any time.

Signature:_____

SOL-0513-270 (R-0317) (Eng.)

TRIPLE-S VIDA

AUTHORIZATION OF PAYROLL DEDUCTION FOR PAYMENT OF PREMIUM CANCER AND DREAD DISEASES POLICY

I authorize my employer _____ to deduct from my salary the amount of $ _____ to pay for the premium of the policy issued by **Triple-S Vida, Inc.** This authorization cancels any prior payroll authorization for payroll deductions in the amount of $_____ for another similar insurance plan with the _____ company in the amount of $_____.

❒ Bi-weekly ❒ Semi-monthly ❒ Monthly

Employee Name and Last Name (please print)	Social Security number	Employee number
Program or Department	Division	
Applicant's Signature	Date	